National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

PART OF THE
LEARNING FROM PRACTICE
SERIES

THE PATH TAKEN:

DEVELOPING ORGANIZATIONAL CAPACITY FOR IMPROVING HEALTH EQUITY IN FOUR ONTARIO HEALTH UNITS

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ABOUT THE NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH

The National Collaborating Centre for Determinants of Health is one of six National Collaborating Centres (NCCs) for public health in Canada. Established in 2005 and funded by the Public Health Agency of Canada, the NCCs produce information to help public health professionals improve their response to public health threats, chronic disease and injury, infectious diseases, and health inequities.

The National Collaborating Centre for Determinants of Health focuses on the social and economic factors that influence the health of Canadians. The Centre translates and shares information and evidence with public health organizations and practitioners to influence interrelated determinants and advance health equity.

1 About the case study

Addressing the health effects and root causes of social inequity is a stated priority in public health, and priority areas for action have been identified by Canada's Chief Public Health Officer.[1] The National Collaborating Centre for Determinants of Health (NCCDH) has further explored the role and capacity of public health practitioners and organizations in Canada to take action on the social determinants of health (SDOH) to improve health equity.

Two environmental scans carried out by the NCCDH in 2010 and 2014[2,3] included literature reviews, key informant interviews, focus groups and surveys of researchers and practitioners at various levels of public health practice across Canada. The conclusions help to lay out the challenges of health equity work, along with roles and strategies for public health practitioners and opportunities to move forward on health equity. Identified requirements for effective action on health equity include leadership, organizational capacity, relevant evidence, staff development and willing partners.[2,3]

Organizational capacity is an essential element for supporting public health action on the SDOH. The recently published Organizational Capacity for Public Health Equity Action (OC-PHEA) framework is helpful for defining the essential elements to guide research, discussion and action on public health capacity development to achieve health equity goals.[4] This case study follows its structure to examine the progress of four public health units (PHUs) in Ontario as they work to embed a SDOH approach into their organization and day to day activities.

The PHUs showcased in this case study are Niagara Region Public Health (Niagara or NRPH), Ottawa Public Health (Ottawa or OPH), Simcoe Muskoka District Health Unit (Simcoe Muskoka or SMDHU), and Sudbury & District Health Unit (Sudbury or SDHU). Each has been working on health equity issues in its own way, and for varying durations. However, they are all harnessing leadership, taking advantage of supportive organizational structures, using local evidence, training staff, and forging deeper partnerships in the community. Each PHU has strengths and approaches that work in their particular context, while maintaining a number of common characteristics and features. Examples of unique aspects of their work are profiled in vignettes interspersed throughout this case study. The diversity of paths and lessons learned while integrating a health equity approach provide interesting real life examples for other public health organizations working to strengthen their own approach in this area.

2 Addressing Health Equity as Public Health Organizations

There has been a gradual shift in how the SDOH have been integrated into Canadian public health practice. The NCCDH's 2010 environmental scan showed that, while there was considerable discussion of the SDOH across Canada, concerted action seemed to be limited to "early adopters/innovators".[3] Most public health organizations had not yet institutionalized practices that centred on addressing health inequities. This was attributed in part to high variability in staff and organizational capacity, including limited skills in epidemiology; community engagement, mobilization and development; and advocacy work. Other barriers named in the report included a lack of clear understanding of the role of public health in addressing health inequities, limitations in evidence, limited leadership and effective communications, and unsupportive organizational and political environments. According to the scan, public health practice appeared to focus mainly on behaviour and lifestyle approaches at that time.

By 2014, a review of the situation showed a positive shift. While some of the concerns of the 2010 environmental scan were reiterated, participants reported a more positive context and increased action to advance health equity in public health practice.[2] Improvements were noted mainly in the areas of attention, interest and dialogue in the subject, including a commitment to health equity action at all levels of public health. Evidence of a health equity lens was found in the analysis and reporting of health data, and in research initiatives. In addition, numerous examples of health equity action were noted from other sectors, including municipalities, non-governmental organizations, and community based groups.

Despite the additional attention to the issue, participants in the 2014 environmental scan remained cautious about whether the momentum had translated into measurable changes to health inequities.[2] However, they did identify a number of opportunities:

- many examples of newly established structures and organizational supports for health equity (e.g. dedicated staff positions, steering committees, strategic plans);
- leadership in health equity initiatives, although it continued to vary greatly;
- engagement of health sector partners, which showed promise in initiatives such as embedding health equity standards into healthcare improvement, engaging the public in discussions about health equity, and creating tools for primary care providers; and
- expansion of health equity networks and alignment of health equity priorities.

Skill and competency development in health equity assessment and surveillance, research and evaluation, policy analysis and advocacy, and community engagement are cited among the needs in the report.[2] In addition, the need for clear terminology and messages for health equity that resonate beyond the public health sector continue to be listed as essential.

Progress has been made across Canada in the years between the NCCDH's initial and follow-up environmental scans to influence health for all.[2] A number of public health organizations are demonstrating how to build on these opportunities in diverse ways, including the four that have contributed to this case study.

AGENCY VIGNETTE

NIAGARA REGION PUBLIC HEALTH STRATEGY – BUILD FROM WITHIN

To build a strong foundation for its work on the social determinants of health, Niagara Region Public Health began a three-phased approach to train staff on SDOH and health equity in 2010. Working from within, and with the support of its senior management team, Niagara developed SDOH champions from various disciplines within the health department to train their peers. Through interactive workshops, using the Last Straw board game as a learning tool, eight champions were trained, and then engaged to support and promote implementation of the next phase of the SDOH strategy: program specific training to help public health staff move SDOH theory into the practice. In 2012, a series of workshops was held to provide staff with an opportunity to apply SDOH knowledge, skills, concepts and theories to their daily program work. A SDOH Menu of Tools was developed and provided to support the unique program and job role needs of public health staff.

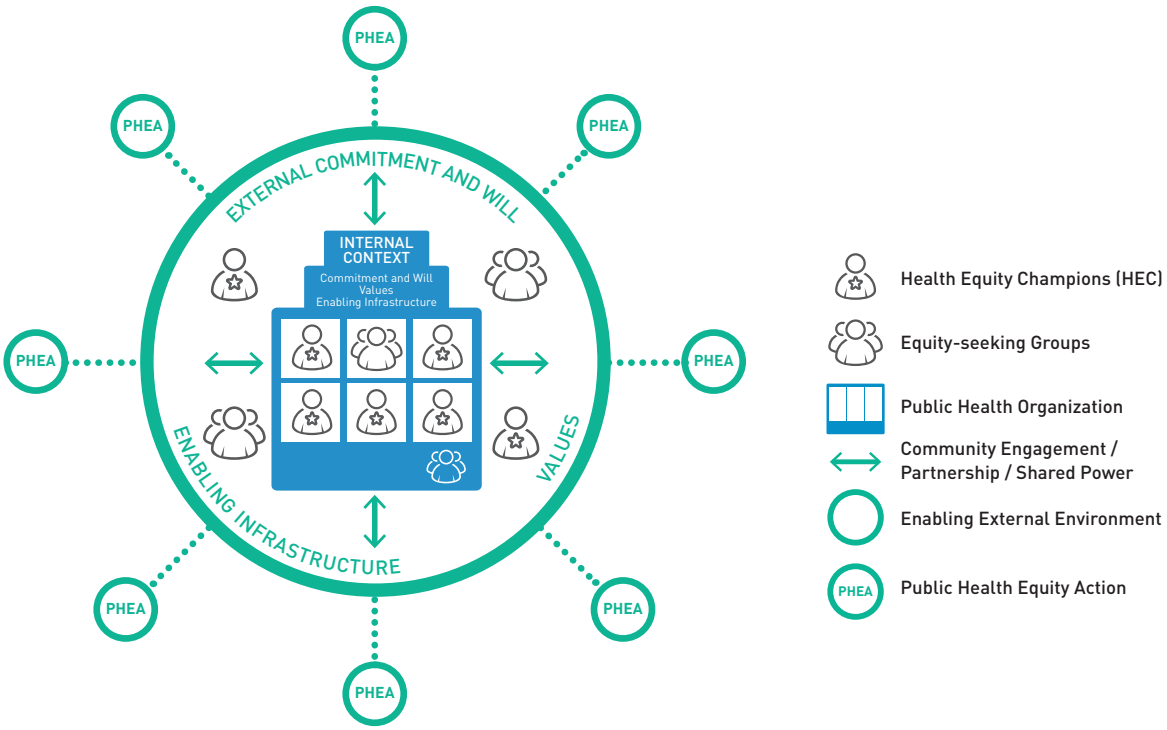
Evaluation of the process has shown that, six months following training, over 60% of respondents indicated they used one or more of the SDOH tools in their daily work. Phase 3 of the approach focused on overcoming barriers to using the Menu of Tools by incorporating it into program planning and evaluation. Over the course of this three phased approach, the pool of SDOH Champions was renewed and provided with additional training. Finally, a SDOH / Health Equity framework is in development for Niagara Region Public Health.

- Key lessons the development team learned include:
- Involve senior management in SDOH work from the very beginning.
- Incorporate an evaluation strategy to ensure ongoing support and to inform future direction.
- Be prepared for a long process to move theory into practice. (In Niagara it took 3.5 years to move from initial training to the beginning of Phase 3.)
- Use adult learning principles and engage front-line staff in all divisions for success. A peer to peer approach and cross-disciplinary learning takes best advantage of the extensive, varied experience of practitioners.

3 Capacity, Roles and Strategies for Public Health Equity Action

The four PHUs presented in this case study are diverse, but share a commitment to strong organizational capacity to reduce health inequities within their populations. Until recently, no framework existed to capture all the necessary aspects of public health capacity required to achieve health equity goals. In 2013, the framework for Organizational Capacity for Public Health Equity Action (OC-PHEA) was developed through consultation with a range of Canadian public health equity champions.[4] This framework can be helpful to guide research, discussion and action on public health capacity development to achieve health equity goals. It has been used in combination with the roles and strategies for public health action to reduce health inequities described by the NCCDH as a structure to organize this case study.[2,3,5]

3.1 Organizational Capacity for Public Health Equity Action (OC-PHEA)



The OC-PHEA Framework is particularly helpful as it identifies factors in the internal and external environments that influence an organization's capability to act. By highlighting shared values, demonstrated commitment and will, and enabling infrastructure, it recognizes that public health action on health equity is very much bound by the relationships and influences of its communities, and the structures and systems within which both operate. The two-way arrows between the domains highlight their reciprocal influence, ideally through community engagement, cross-sectoral partnerships, and shared power. A number of players, both inside and outside of public health, influence the success of endeavours, including champions and members of equity-seeking populations.

Following the OC-PHEA Framework, this case study briefly addresses the external context before focusing on the internal environments that facilitate action on health equity within the four PHUs studied.

3.2 Roles for Public Health Action

No organization in Canada embarks on the challenge of driving change on the social determinants of health under ideal circumstances; it is difficult to have all of the elements required for seamless action to improve socially determined health outcomes. However, the four Ontario PHUs in this case study have made significant gains as they develop their organizational capacity to move forward on health equity within their respective communities.

In 2014 the NCCDH identified four key roles for public health action on health determinants to reduce health inequities:[5]

- **Assess and report** on the health of populations to describe the existence and impact of health inequalities/inequities and effective strategies to address them.
- **Modify/orient** public health interventions to reduce inequities including the consideration of the unique needs and capacities of priority populations.
- **Engage** in community and multi-sectoral collaboration to address the health needs of these populations through services and programs.
- **Lead/participate** and support other stakeholders in policy analysis, development and advocacy to improve health determinants/inequities.

Participants in the 2010 environmental scan suggested that a number of elements are necessary for these roles to be undertaken most effectively[3]

- **Leadership** that is collaborative
- **Organizational and system development** within and outside the health sector
- Development and application of **information and evidence**
- **Education and awareness raising** for public health staff and the general public
- **Skill development** based on participatory learning
- **Partnership development** inter- and intra-sectorally

These roles and elements are apparent in the actions of the four PHUs profiled in this case study. The experience of each health unit shows that the roles do not work in isolation and that momentum can result from the convergence of several factors at once. Those interviewed for this case study generally experienced this shift not as the build up to a "tipping point", but more as a system creating the right conditions for effective health equity action in their organizations. The similarities and differences in their approaches speak to the importance of understanding the culture and environment that organizations work under, and being flexible enough to take advantage of opportunities as they arise.

4 External Environment

Public health in Ontario is organized around local PHUs governed by boards of health. Just over two-thirds of Ontario's boards of health are autonomous bodies created to provide local public health services. Municipal councils act as the board of health for the remainder. Specifically there are:

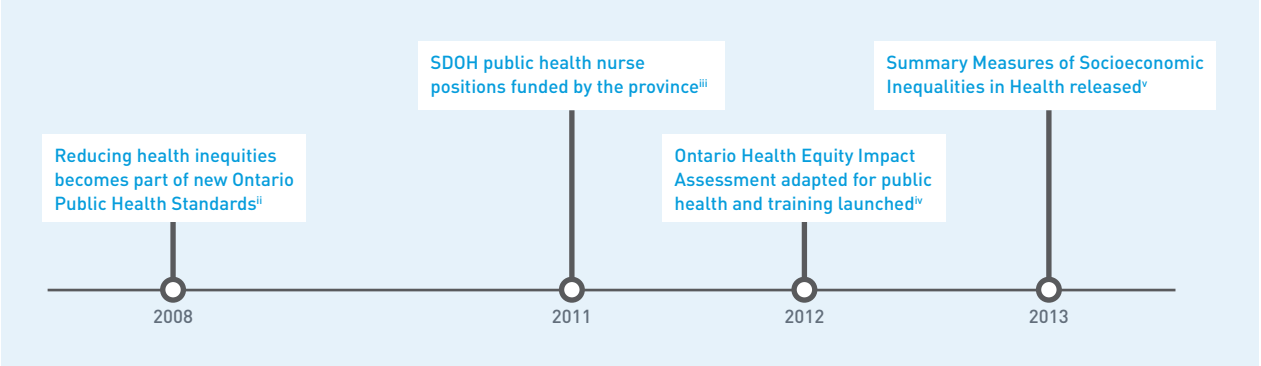
- 22 autonomous boards that operate separately from the administrative structure of their municipalities;
- 4 autonomous boards that are integrated into municipal structures;
- 4 boards that are councils of single tier municipalities; and
- 6 boards that are councils of regional municipalities.[6]

Regardless of the structure, all boards of health have the same responsibilities. Boards are made up of municipal members, either elected officials or community representatives, and provincial appointees where requested. In this case study, Simcoe Muskoka and Sudbury follow the autonomous board structure, Ottawa follows the integrated municipal structure, and Niagara follow the regional structure.

Ontario public health units collaborate with other health service providers in various ways, including primary care providers, community health centres, and Local Health Integration Networks (LHINs).[i] The LHINs are designed to plan, integrate and fund health care services, including hospitals, community care access centres, home care, long-term care and mental health within specified geographic areas.

At the same time as individual health units in Ontario were building their capacity to integrate equity considerations into their programs and services, the provincial government was renewing its public health strategy and related plans and tools. Some of this work, such as embedding health equity into the Ontario Public Health Standards, received strong support and encouragement from individual champions and public health units. As the OC-PHEA Framework recognizes, internal and external environments influence each other to create change.

THE FOLLOWING BENCH MARKS DOCUMENT KEY PROVINCIAL ACHIEVEMENTS AND PROVIDE A PERSPECTIVE ON THE EXTERNAL CONTEXT FOR THE WORK OF THE PUBLIC HEALTH UNITS IN ONTARIO.



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[iv] Ontario Ministry of Health and Long-Term Care. Health Equity Impact Assessment (HEIA) workbook [Internet]. Ottawa (ON): Government of Ontario, Ontario Ministry of Health and Long-Term Care; 2012 [cited 2015 Mar 6]. 44 p. Available from: www.health.gov.on.ca/en/pro/programs/heia/docs/workbook.pdf

[v] Ontario Agency for Health Protection and Promotion. Summary measures of socioeconomic inequalities in health. Public Health Ontario. 2013 [cited 2015 Mar 6]. 67 p. Available from: www.publichealthontario.ca/en/eRepository/Summary_Measures_Socioeconomic_Inequalities_Health_2013.pdf

AGENCY VIGNETTE

OTTAWA PUBLIC HEALTH'S JOURNEY TO IMPROVE HEALTH EQUITY

Ottawa Public Health (OPH) has a long history of collaboration with community partners to reach priority populations. However, the release of the World Health Organization's *Closing the Gap in a Generation* (2008),[10] helped create greater momentum towards a more coordinated approach to achieve health equity goals.

OPH reached a number of key milestones as a result of deliberate, planned transformations at an organizational level to support health equity efforts. Among them are:

- the OPH 2011-2014 Strategic Plan, with specific priorities to reduce health inequities;
- the development and gradual integration of a performance measure to monitor and foster the systematic application of HEIA for new projects or programs.
- a health equity team, established to strengthen OPH-wide, collective leadership for health equity.

At the same time, staff involvement in community initiatives, champions at various levels in the organization, and changes in the socio-political and economic environment have resulted in real changes for clients. Concerted action with other sectors has addressed education, housing and social services, with integrated programming now in place for priority population groups.

For example, OPH's approach to Aboriginal health has changed significantly. Championed by Dr. Vera Etches, the Deputy Medical Officer of Health, the Urban Aboriginal Health Program is clearly focused on health equity. Kim Trotter, a SDOH-PHN whose role includes that of Aboriginal Health Liaison, sees a much greater department and City-wide commitment to urban Aboriginal health and well-being. This was as a result of a number of factors, beginning with the growing body of evidence relating Aboriginal health inequities to the SDOH, and strengthened by the collaborative efforts of community partners and the City's multi-disciplinary and inter-sectoral Aboriginal Working Committee.

Specific changes in the Urban Aboriginal Health Program include:

- a more systematic and comprehensive approach;
- more coordination and integration of teams and action;
- greater accountability, including explicit deliverables and performance measures;
- support for staff participation on an internal OPH Aboriginal Outreach Network;
- increased support for cultural competency training in recent years; and
- designated staff liaisons working with Aboriginal community partners.

Kim concludes that, "We are making significant strides on our journey towards health equity. With a developing shared understanding and vision; visible, vocal champions; greater collaboration among partners; and health equity as a key operational imperative for OPH, I am confident that we will continue to gain momentum in 2015."

5 Internal context – Organizational infrastructure

The internal context that enables health equity action at the four PHUs featured in this case study is addressed in this section: commitment and will, values and enabling infrastructure.

> Like most health units, we have a long history of caring deeply about the well-being of disadvantaged populations, but we didn't carry out health equity or priority population work in a formal or consistent manner. Now, that work is becoming more purposeful, more consistent, more comfortable, and more routine.

DR. LISA SIMON
SIMCOE MUSKOKA DISTRICT HEALTH UNIT

5.1 Commitment and Will

Sometimes commitment to health equity comes in the form of a dedicated person, a champion who takes on the cause. In other cases, senior management recognizes the importance of this approach, and put in place measures to support action on the SDOH. Any combination of factors can stimulate action, but the support of senior management is key.

A senior staff member, like a Medical Officer of Health, has the advantage of being able to garner the broad support of senior management. In Ontario, the MOH is also responsible for the administration of the entire PHU, which provides another lever for influence. Sudbury's Medical Officer of Health, Dr. Penny Sutcliffe, embodies the strong, supportive leadership that stimulated action at that health unit. One of the first initiatives Dr. Sutcliffe carried out, in 2005, was gaining endorsement for SDHU's Determinants of Health Position Statement from the Board of Health.

In Niagara, with the full support of senior management, champions were recruited and developed from staff who were passionate about health equity. Through training and the support of their managers, they were able to work from within to spread knowledge and skills related to SDOH using a peer-to-peer approach.

All four of the PHU's profiled cite an agency-wide commitment to health equity, as evidenced by SDOH being either an explicit priority or having been purposefully embedded in strategic priorities. They have also fully embraced provincial initiatives, including instituting Ontario's Health Equity Impact Assessment (HEIA)[7] and using the funding for SDOH public health nurses to full advantage. Agency-wide support for health equity work signals the fact that it is not just the role of designated staff, but everyone's responsibility to incorporate into their work.

Staff development and training is another clear sign of management's support and financial commitment to health equity. This can be seen in Niagara, where all levels of management supported employees' time and effort to participate in training and take on the role of SDOH champions. The development of an SDOH 'Menu of Tools' and staff training to apply health equity theory to practice demonstrates their ongoing commitment to these efforts.

At OPH, the development of a cohesive and coordinated health equity leadership has become a priority. The goal is to identify champions and existing assets across the organization and establish a health equity leadership committee that will guide and support staff awareness and training on health equity. In Simcoe Muskoka, management has supported a full day of training in SDOH for all staff. According to Rebecca Dupuis, the SDOH PHN at the time, "Even before the day started, the fact that management supported a full day of training sent a strong message of its importance to us as an Agency."

5.2 Values

The values of an organization are grounded in its people. A consistent view of participants in this case study was the belief that people come to public health with professional core values grounded in the importance of health equity and social justice. Sometimes these values are driven by leadership from the top. Other times, front-line workers play a leading role; they see the circumstances their clients live in and are motivated to change the underlying factors that prevent them from becoming healthier.

> Health equity is ingrained in our dental team, because of their personalities and because of the nature of their positions. They are more frontline than most at the health unit and see the potential to change lives on a daily basis.
>
> MARTHA ANDREWS, SUDBURY & DISTRICT HEALTH UNIT

Regardless, leadership is key and is made more powerful when combined with the inherent values of the team as a whole. It can be challenging to spread health equity values throughout a health organization and beyond. Several of the PHU's profiled spoke to the benefit of having a tool to stimulate conversation. The video developed by SDHU, "*Let's Start a Conversation About Health . . . and Not Talk About Health Care at All*"[8] was used in a number of settings, with staff, stakeholders and decision-makers. The board game, *The Last Straw*[vi], was a key learning tool for Niagara's champions. Both offered opportunities for sharing and dialogue and fostered growth and thinking about individual and public health roles.

A number of practitioners interviewed expressed gratitude to their colleagues for the history, experiences, relationships and value they bring to their work, recognizing that health equity work must be built on a strong foundation. Open-mindedness, an understanding and sensitivity towards priority populations, a collaborative approach and strong listening skills were some of the practical illustrations of the value set required to promote health equity.

Another key attribute is a belief in the importance of evidence. Access to high quality data and evaluation results help gain the support of management and partners outside of public health. The data uncovered in the Ottawa Neighbourhood Study (ONS) or the Geographic Information System (GIS) mapping that is part of Niagara's SDOH approach help to direct programming, but also to demonstrate the great potential of applying a health equity lens, supported by reliable data, at all program stages, from the identification of priority neighbourhoods, to the collaborative design and implementation of actions to tackle local priorities identified by residents. On the downside, a lack of hard evidence is sometimes cited as a reason not to pursue health equity approaches by management or funders. While the lack of critical evidence (and the resources required to generate it) are undeniable gaps that need to be addressed, the increasing pressure on PHUs and partners to provide "hard data" on health equity is being accompanied by the realization that hard data does not tell the whole story.

[vi] Reeve K, Rossiter K. The Last Straw [Internet]. Ontario: [publisher unknown]; c2007 [cited 2015 Mar]. Available from: http://nccdh.ca/resources/entry/the-last-straw

5.3 Enabling infrastructure

More than any other element, participants mentioned infrastructure as enabling their work in health equity. Common components included:

- strategic and operational plans that prioritize health equity;
- multi-disciplinary, multi-level guiding or steering committees to set supportive policies and procedures and ensure interaction between and across levels;
- health equity teams, offices or units supporting SDOH work, either at the organizational level or within selected programs;
- GIS mapping, situational assessments and other elements of "purposeful reporting" designed to identify priority populations;
- more systematic health equity-focused assessments, monitoring and evaluation to allow programs to focus and shift efforts if required;
- SDOH tools, training and other resources to support staff;
- support to engage with community partners through external committees or area-specific efforts.

Health equity teams were positioned in various ways in the four PHUs studied. In Sudbury, the Health Equity Knowledge Exchange and Resource Team (HEKERT) is an inter-disciplinary, interdivisional group that serves the entire health unit. Its structure ensures broad representation, communication and buy-in across the health unit. Niagara used a "bottom-up" or grass-roots approach, with members of its interdisciplinary SDOH team embedded in the Clinical Services and Family Health Services groups among others. It also established a SDOH Health Unit Working Group to provide a connection across the Agency.

Among health equity resources, those mentioned most frequently included tools to:

- raise awareness and stimulate discussion, e.g. *Let's Start a Conversation*[8]
- support practice with evidence, e.g. *10 Promising Local Public Health Practices to Reduce Social Inequities in Health*[9]
- guide efforts, particularly the Health Equity Impact Assessment (HEIA) tool.[7]

All of the PHUs featured in this case study have used the HEIA, to a greater or lesser extent, and support its value on a number of fronts. In Simcoe Muskoka, HEIAs are now required in every program, taking health equity responsibilities throughout the entire agency and building skills. In addition to identifying the implications of programs and pointing to any required changes, "Just having done them has really helped to further the general comfort with and commitment to health equity work throughout our organization," according to Dr. Lisa Simon, Associate Medical Officer of Health at Simcoe Muskoka. The process has made HEIA work tangible. Dr. Simon cites this seemingly small decision as pivotal to their success in integrating health equity. "People can grasp, learn, implement and run with it. They realize that it's doable and feasible, and can lead to some real potential valuable change."

Monitoring tools were cited as very important to evaluating outcomes and maintaining management support. However, some PHUs noted that they were still at the stage of evaluating processes, such as access to services and the number of community requests filled. They looked forward to having measures that would allow them to assess impact within their programs and in the broader community.

While all of the infrastructure elements are important, integrating them into systematic, comprehensive and coordinated plans appeared to be the key to moving forward on health equity initiatives.

AGENCY VIGNETTE

FINDING THE EVIDENCE FOR PRACTICE: A CHAMPION KICK-STARTS SUDBURY'S HEALTH EQUITY WORK

Medical Officer of Health, Dr. Penny Sutcliffe, started Sudbury's journey to improve health equity back in the early 2000's. The process focused on changing the organization's internal culture to support health equity work, while working to create, and then leveraging, external opportunities.

Efforts began locally by securing Board of Health support for Sudbury's Determinants of Health Position Statement. At the same time, work began on changing the external environment by engaging with the provincial government and Ministry of Health so that they would provide the necessary context and direction at the local level. This included advocating for the SDOH to be included in the Ontario Public Health Standards.

This was followed by an internal focus to provide evidence for practice and create structures to ensure their own house was in order, regardless of what the province decided to do. The leadership team worked to identify effective local public health practices to address social inequities, resulting in the what has become the well-known *"10 Promising Local Public Health Practices to Reduce Social Inequities in Health"*.[10] These practices were identified and summarized with the help of funding from the Canadian Health Services Research Foundation's Executive Training for Research Application (EXTRA) program. They became the evidence base for the development of organizational tools, structures and human resources to implement the 10-year health equity vision and plan.

Identification of the promising practices led to the development of number of communication tools to support implementation. This included a social marketing tool to support staff to engage the public, as well as decision makers and internal staff, in a discussion about health equity. Released in June 2011, the five-minute video *Let's Start a Conversation About Health . . . and Not Talk About Health Care at All*[8] became a 'smash success' in public health terms, going 'viral' among community decisions makers, agencies, citizen groups and other PHUs. The video and conversation guide highlight the fact that health is related far more to individuals' social and economic conditions than to medical care. The tool has helped Sudbury staff plan public health programming, but more than that, it has sparked both conversation and action towards healthy public policy and the reduction of health inequities.

SDHU and many other PHUs continue to use *Let's Start a Conversation* to frame health equity issues, raise awareness, and build understanding of the social determinants of health inequities with diverse community members and stakeholders. It also serves as a catalyst for action around a number of promising practices, including intersectoral action, community engagement and social marketing.

6 People and Relationships

6.1 Health equity champions

As noted previously, champions can instigate initiatives in health equity as senior leaders or as front-line staff.

Dr. Penny Sutcliffe was a 'game-changer' in Sudbury. She has been named as the key driving factor to implementing a health equity approach in that region. Staff reported that "there was purposeful planning that included decision makers from the most senior level of the organization." Clearly, the values in place at the senior management level, coupled with a base of values and receptivity of staff provided a good launching pad. The value of a champion at a senior level, though, is that she has the ability to make sure the focus remains on health equity even in the face of competing pressures.

The champion-forming process in Niagara, on the other hand, meant that staff were hearing from their peers – an effective adult learning approach. Champions were not self-proclaimed 'experts' on SDOH, they were simply co-workers with a passion for the subject. The 'champions model' gave them a platform, and an opportunity to learn from one another. Peer champions, had the advantage of coming from among the staff and being more available for mentoring.

A number of examples were also noted of staff who became mentors to their peers. For example, Stacey Allegro is a SDOH sexual health outreach nurse in Niagara. Her work stimulated the interest of staff in all areas of public health. Many staff members have asked to shadow her, and adopt the harm reduction principles she has been using in her daily work for years. They are now identified as health equity initiatives, raising the profile of her work and its impact on the health of her clients.

The cross-disciplinary, multi-level nature of many of the health equity committees active in PHUs puts members in a position to influence others across their organizations. Along with the SDOH nurses in place, Miranda Berardelli, a public health inspector on the HEKERT team in Sudbury, is often called upon to respond to questions regarding health equity. A great number of public health practitioners have developed significant expertise and competence over the years, which is now being recognized as particularly valuable to achieving organizational health equity goals.

6.2 Equity seeking groups

Given the increased role of public health in equity issues as demonstrated in the four PHU's that contributed to this case study, community groups are increasingly coming to see the potential of public health as a strong ally. Groups that may have already had a good relationship with certain practitioners, are coming to PHUs with requests for services that may not have been considered in the past. Rather than saying, "That's not us," practitioners are now looking at issues more broadly, wondering if the issues raised could perhaps be part of a health equity approach.

Ottawa's Poverty and Hunger Working Group, described in greater detail later in this case study, is an excellent example of community organizations and public health working collaboratively with community members to address issues that affect their lives. The Group's mandate is to increase access to healthy foods. Jamie Hurst, a public health nutritionist at OPH, notes that the Poverty and Hunger Working Group was instigated, and is led, by the community. "The communities themselves identify their most significant challenges and ultimately, shape the projects that the Group focuses on."

A common theme from the PHUs described in this case study is that community partners are responding very favourably to the greater opportunities for collaboration and inclusion in public health conversations. They appreciate the broader understanding of their health issues, and in turn, look to public health for support in other areas, such as advocacy.

6.3 Community Engagement and Partnership

Community partnership is one of the four pillars of the Ontario Public Health Standards, and a hallmark of public health. Efforts are moving towards greater openness in collaborative work, with public health sometimes taking a leadership role and sometimes focusing on support for community organizations.

Public health has always consulted its client base to some extent. Now, they are engaging more deeply with marginalized populations and finding more collaborative and participatory solutions to issues, based on participants' strengths. According to one practitioner, "It's citizens' voices that make a difference."

In Niagara, the Priority Populations Working Group, a multidisciplinary team from across the health unit, engage with subject matter experts from the community. They exchange information on how each group can support the other, and often find better ways to service clients through existing mechanisms.

Ottawa Public Health is offering falls prevention classes for those 65 years and older, in collaboration with the City of Ottawa's Parks, Recreation, Cultural Services Department. The program was planned with health equity in mind, with ONS data determining the location of courses, based on where seniors are located and public transportation is more readily accessible. Becoming aware that many Chinese-speaking clients could benefit from the classes, they are now wondering if their programs would be more accessible if offered in other languages besides English and French.

6.4 Shared power

Working on health equity, public health practitioners recognize that they don't "own" the issues. Their input and voice is valued, but the root causes of health inequities go beyond the realm of public health, to the inter-related SDOH that require concerted intersectoral action and a whole-of-government approach. External collaborations are the key to going "upstream". An added benefit to this approach is that a shared perspective provides a more nuanced and persuasive voice. Also, resources are scarce, and often best used when organizations share resources and knowledge.

An excellent example of a shared approach is Ottawa's Poverty and Hunger Working Group, an active coalition of over 30 organizations with representatives from the City, community, and academic environments. With a mandate to increase access to affordable and culturally appropriate food for people living in poverty, the group has implemented two community-led and volunteer-run projects: Good Food Markets, whereby fresh produce is bought and resold at cost to low income communities far from grocery stores, and the Market Mobile which provides the same service through a chartered bus that goes into communities that require it. Both of these projects were initiated by the community, thus they are in charge of shaping any required changes. The project supports some of the city's most vulnerable populations, and has the added benefit of demonstrating the value of a health equity approach to a number of City departments that traditionally have not been involved in food security dialogues.

According to Jamie Hurst, public health nutritionist at OPH, these projects are changing the way the City approaches poverty. "We are starting to change the mindset that food banks are the sole solution to food insecurity. There is greater discussion around the need to advocate for systemic changes that will result in individuals having more money."


PLEASE
GIVE!

AGENCY VIGNETTE

SIMCOE MUSKOKA'S PATH TOWARDS HEALTH EQUITY

Like many other public health units, Simcoe Muskoka's health equity efforts had gone un-named and unheralded for years. Starting in 2007, however, the health unit began working more purposely to address the SDOH. Motivated by the Ontario Public Health Standards, and two successive agency Strategic Plans (2007-2011 and 2012-2016) that identified the determinants of health as a priority, the agency moved ahead through a phased-in implementation approach:

1. "Learning" phase (2007-2011) – aimed at increasing staff capacity through a series of education and awareness opportunities;
2. "Understanding" phase (2012) – designed to increase organizational capacity, including identifying roles, building staff capacity, and working with health equity champions throughout the organization;
3. "Shifting" phase (2013) - in which the SDOH PHN positions were moved to a centralized service area within the agency, to support, implement and entrench health equity work throughout the organization, and community collaborations and advocacy activities were enhanced;
4. "Acting" phase (2014) – wherein SDOH was integrated into operational planning, by more fully engaging the management group through a specially designed curriculum on health equity, and the first agency-wide priority population was identified through a rigorous situational assessment; and
5. "Integrating, Adapting & Emerging" phase (2015 and Beyond) – when the action plan for the first agency-wide priority population will be finalized and begin implementation.

Simcoe Muskoka's health equity emphasis can be seen throughout all programs, including Health Connection, the health unit's information and advice service for the public. To start integrating health equity into practice, all health unit programs were required to conduct a health equity impact assessment (HEIA) on a program, policy, service or initiative. Using that tool, it was discovered that Health Connection wasn't being well-used by individuals and families of low income, those who did not have access to transportation, or who were experiencing poor housing.

As a result, Health Connection reached out to people living in low income through service providers who support this priority population to determine how to improve the service. The results will be used to reorient how Health Connection provides public health information and services to better reach and benefit this population.

7 Success Factors and Potential Tensions

7.1 Success factors

While each PHU featured in this case study approached health equity in its own unique fashion, a number of similarities can be drawn. All PHUs recognize the increased attention being given to health equity. "Priority populations", "health equity impact assessments" and "social determinants of health" are frequently heard in conversations, presentations and reports. There is a positive attitude, even passion, towards health equity work. "People feel good and want to do better and are looking for more tools and more knowledge," says Dr. Lisa Simon, of Simcoe Muskoka. Niagara's Stacey Allegro sees positive signs that their organizational culture is changing: "Silos are being removed and there is more collaboration."

Structural changes in both the external and internal environments also figure into the stronger focus on health equity in each PHU. The provincial funding of the SDOH PHN's, the Ontario Public Health Standards, champions at various levels, and health equity as a priority in strategic and program planning are common features. Multi-disciplinary, multi-level guiding or steering committees are in place in all four PHUs, and evidence features prominently, gathered through HEIAs, GIS-mapping, evaluations and efforts to disaggregate health data by socio-demographic factors where possible. Finally, active communications strategies and partnerships are used to engage staff, community organizations, decision makers and sometimes the general public in health equity.

7.2 Potential Tensions

At the same time as the PHUs featured in this case study are celebrating the progress they have made, none of them would say their journey has been smooth. They still struggle with significant dilemmas:

- **What is our mandate?** There is a common view that public health should focus on a broad, population-based approach, which is often interpreted as reaching the population at large. Yet achieving equitable outcomes requires targeting within universal approaches that address the underlying causes of disadvantage. How does public health find the right balance?
- **Are we crossing boundaries?** Public health organizations' focus is on health. At the same time, the broader SDOH may be perceived as falling outside of health's mandate. How can public health demonstrate that addressing the political and social nature of health equity remains within its mandate?
- **When does support for health equity become the standard approach?** While all PHUs support the SDOH within their time-limited strategies, how can that be translated into the ongoing "way we do business"? How can health equity champions, at various levels in the organization, lobby senior management to make sure this critical view is maintained and translated into operational budgets and priorities?

- **Is there a common and mutual understanding?** Senior management and individuals at various levels champion health equity, but PHUs are not homogeneous organizations and they are working in diverse communities. Views about health equity vary enormously, and these differing values and ideologies are often implicit. How can we foster a safe environment where differing views can be openly and critically discussed to help build a common and mutual understanding on health equity while engendering support throughout public health organizations and beyond?
- **Can "objective science" values and "social justice" values converge in action?** A science-based or objective approach to public health is generally accepted, while a rights-based approach to health may be perceived as ideologically charged. Can public health work bridge this gap, engaging both scientific evidence and equity values to improve the health of everyone?
- **How can PHUs take best advantage of their organizational structure?** There are various configurations of public health across Canada. In Ontario some health units operate as autonomous organizations, and others are integrated into municipal government services. Integration may facilitate intersectoral work, but it can also constrain public health to align itself with city agendas. How can public health organizations work most effectively within the structure they have?

Resolving these tensions is an ongoing challenge, but insight can be found in the OC-PHEA Framework, which captures the significant level of exchange between the external and internal environments that is required to support the work of health equity. It is the interaction of players at all levels that is necessary to build capacity for action. As can be found throughout this case study, capacity for action on the SDOH and health equity is often driven by the convergence of several factors internal and external to public health. This capacity can instigate action that results in meaningful change.

QUESTIONS TO CONSIDER

1. What part of the OC-PHEA Framework is most relevant to your context? Which elements are making a significant contribution to your capacity?
2. Of the identified tensions, which are most important in your organization? How can you facilitate a conversation to explore and resolve these tensions?
3. Now that you have learned a bit about the different paths taken by four Ontario public health units, how does the path of your organization compare? What will you take from these examples to apply in your local context?

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